MEDDAC Memorandum 40-33

Medical Services

Identifying and Reporting Suspected Abuse

Headquarters
U.S. Army Medical Department Activity
Fort George G. Meade
2480 Llewellyn Avenue
Fort George G. Meade, MD 20755-5800
11 September 2002

Unclassified

SUMMARY of CHANGE

MEDDAC MEMO 40-33
Identifying and Reporting Suspected Abuse

Specifically, this revision—

- Has been published in a new format that includes a cover and this "Summary of Change" page.

- Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.

- Updates the information for contacting the on-call social worker (para 2-3a(2)).

Department of the Army
Headquarters
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*** MEDDAC**
Memorandum 40-33

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Identifying and Reporting Suspected Abuse

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Summary. This memorandum esabishes policies and procedures and responsibilities for identifying and reporting cases of suspected child, spouse or vulnerable adult abuse or neglect.

Applicability. This memorandum applies to Headquarters, U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC) (Kimbrough Ambulatory Care Center (KACC)).

Proponent. The proponent of this memorandum is the Deputy Commander for Nursing (DCN).

Suggested improvements. Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to Commander, US Army Medical Department Activity, ATTN: MCXR-DCN, 2480 Llewellyn Ave., Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

Distribution. Distribution of this publication is by electronic medium only.

Contents (Listed by paragraph and page number)

* This publication supersedes MEDDAC Memo 40-33, dated 25 January 2001.

contents–continued

Chapter 1
Introduction

1-1. Purpose
This memorandum prescribes responsibilities, policies and procedures for identifying and reporting suspected cases of child, spouse or vulnerable adult (geriatric or the developmentally disabled) abuse or neglect; except for sexual abuse, which is addressed by MEDDAC Memorandum 40-26.

1-2. References
Required and related publications are listed in appendix A. Prescribed and referenced forms are also listed in appendix A.

1-3. Explanation of abbreviations and terms
Abbreviations and special terms used in this memorandum are explained in the glossary.

1-4. Responsibilities
a. *The MEDDAC Commander and Executive Committee*. The MEDDAC Commander and Executive Committee will establish a physical, social and cultural environment that promotes special sensitivity to patient rights and safety.

b. *The Deputy Commander for Clinical Services (DCCS)*. The DCCS will ensure that all credentialed providers receive training and education concerning assessing and identifying actual or potential abuse or neglect, medical examinations and documentation thereof, and all mandated reporting procedures.

c. *The DCN*. The DCN will ensure that all nursing personnel receive training and education concerning assessing and identifying actual or potential abuse or neglect, medical examinations and documentation thereof, and all mandated reporting procedures.

d. *Chiefs of clinical services*. Chiefs of clinical services will—

(1) Ensure that all personnel who come in contact with patients receive training and education on identifying actual and potential abuse or neglect and what actions to take to report their findings and/or suspicions to the appropriate provider.

(2) Coordinate training and education on an annual basis or more often, as indicated by the patient population or identified staff needs.

(3) Ensure that proper procedures are followed for all reported cases.

e. *Health care providers*. Health care providers will—

(1) Routinely assess their patients for signs and symptoms of possible abuse or neglect.

(2) Consult the Chief, Family Advocacy Program (FAP), Social Work Section (SWS) for further assistance and guidance when abuse or neglect is identified or suspected.

(3) Gather forensic evidence and complete the proper documentation in accordance with guidance provided by SWS and/or other agencies.

f. *The Chief, FAP*. The Chief, FAP will—

(1) Provide assistance and guidance on abuse and neglect issues to health care providers and other members of the staff.

(2) Provide an on-call roster to the Chief, Family Health Clinic and the Administrative Officer of the Day for after hours coverage.

(3) Coordinate with the military police, child protective services, adult protective services,

and other outside agencies as indicated.

(4) Ensure that patients are released to safe environments.

(5) Comply with the provisions of AR 608-18.

g. *The clinical staff*. The clinical staff will—

(1) Identify possible signs and symptoms of abuse or neglect in children, spouses and vulnerable adults and know the mechanism for reporting concerns or suspicions.

(2) Maintain a non-judgmental and professional attitude, and ensure patient confidentiality and privacy during all data gathering procedures.

1-5. Use of masculine gender pronouns

Throughout this memorandum the masculine gender pronouns *he, him, himself* and *his* will also represent the counterpart female gender pronouns *she, her, herself* and *hers*.

Chapter II
Abuse and Neglect Reporting Procedure, and Follow up Actions

2-1. Education and training of the clinical staff

The clinical staff will receive education and training on the signs and symptoms of abuse and their role in the reporting process. This will be done during orientation and on an annual basis or more often as determined by the service or clinic chief.

2-2. Mandated reporters of suspected abuse or neglect

a. AR 608-18 requires that the maltreatment of military spouses and their children be reported to the FAP, SWS at the installation where discovered.

b. Maryland law requires that certain persons having reason to suspect that a child or elderly or disabled adult is being abused, neglected and/or exploited, reports the matter immediately to the local Department of Social Services. (At KACC, SWS is responsible for making this notification once contacted by a member of the KACC staff.) Persons responsible for making such reports to SWS are—

(1) Any person licensed to practice medicine or any healing arts.

(2) Any hospital resident or intern.

(3) Any person employed in a nursing profession.

(4) Any person employed by a public or private agency or facility and working with adults.

(5) Any person employed as a social worker.

(6) Any mental health professional.

2-3. Essential telephone numbers

a. Social Work Section.

(1) Duty hours. Dial 7-8895/6.

(2) Non-duty hours. Dial the On-call Social Worker's pager, 1-800-759-8888 (PIN 1413377), or the phone number listed on the On-call Social Worker Roster located in the After Hours Clinic, which can be reached by dialing 7-8519.

b. Military Police. Dial 7-6622.

c. Anne Arundel County Department of Social Services. Dial (410) 421-8400.

2-4. Indicators of abuse and neglect

Members of the clinical staff will observe all patients for signs of abuse and neglect. Possible indicators of abuse or neglect may be in the form of physical presentation, unusual behavior or comments made by the patient and/or an accompanying family member.

2-5. Patients in need of immediate protection against abuse

Any member of the clinical staff who believes a patient requires immediate protection from an abuser should call the military police for immediate assistance. (See paragraph 2-3b, above.) Whenever a member of the staff calls the military police into the facility, a courtesy call will be made the MEDDAC Commander's office to inform the commander and deputy commanders that the military police have been called and the reason.

2-6. Reporting suspected abuse or neglect by non-providers of the clinical staff

a. *If the patient has an appointment with a provider*. Any non-provider member of the clinical staff who suspects that a patient is being abused or neglected will privately inform the patient's health care provider of his suspicions.

b. *If the patient does not have an appointment with a provider*. In situations where abuse or neglect is suspected and the patient does not have an appointment with a provider, such as in the Immunization Clinic or the Pharmacy, the staff should report their concerns to the officer in charge (OIC), head nurse (HN), or noncommissioned officer in charge (NCOIC) of the clinic or activity.

2-7. Action providers will take when abuse or neglect is suspected

If a provider suspects that one of his patients is being abused or neglected, he will contact SWS. (See paragraph 2-3a, above.)

2-8. Actions clinical OICs, HNs and NCOICs will take when abuse or neglect is suspected

If a clinical OIC, HN or NCOIC suspects that one of his patients is being abused or neglected, or if such information is brought to his attention by a member of the staff, he will contact SWS for guidance and assistance. (See paragraph 2-3a, above.)

2-9. Immediate actions to be taken by the Chief, FAP or On-call Social Worker

The Chief FAP or On-call Social worker will—

a. Consult with the individual who submitted the telephonic report (that is, the provider, or clinical OIC, HN or NCOIC).

b. If it is determined that a case of abuse or neglect exists or may exist, notify any of the following that he deems necessary:

(1) Military police.
(2) Child Protective Service.
(3) Adult Protective Service.
(4) Other pertinent agencies.

c. Complete the appropriate U.S. Army Medical Command (MEDCOM) form. These forms are available on FormFlow, in the "Medical Command Forms" section. The instructions for completing them are contained in MEDCOM Pamphlet 608-1.

(1) MEDCOM Form 664-R (Child Abuse/Neglect Risk Assessment).
(2) MEDCOM Form 665-R (Spouse Abuse Risk Assessment).

d. Not allow the patient to be sent home to an unsafe environment.

e. Arrange to have the patient transported to Walter Reed Army Medical Center or other hospital if the patient has injuries that require hospitalized care.

2-10. Follow through with the Case Review Committee (CRC)

a. Following a thorough assessment, which will include coordination with providers, the assigned FAP worker will present the case to the CRC.

b. The Deputy Commander for Clinical Services will be notified of all CRC findings of established abuse or neglect and any other reports which may be of command interest.

c. The FAP and CRC will comply with the provisions of AR 608-18 regarding the coding of medical records, notifying the Central Registry, maintaining FAP case records, and transferring open cases when the sponsor relocates.

Appendix A
References

Section I
Required Publications

AR 608-18
The Army Family Advocacy Program. (Cited in paras 1-4 and 2-10.)

MEDCOM Pam 608-1
Family Advocacy Program

Section II
Related Publications

A related publication is merely an additional source of information. The user does not have to read it to understand this publication.

AR 310-25
Dictionary of United States Army Terms

AR 310-50
Authorized Abbreviations, Brevity Codes, and Acronyms

MEDDAC Memo 40-26
Sexual Assault

Section III
Prescribed Forms

This section contains no entries.

Section IV
Referenced Forms

MEDCOM Form 664-R
Child Abuse/Neglect Risk Assessment

MEDCOM form 665-R
Spouse Abuse Risk Assessment

Appendix B
Child Neglect Evaluation Guidelines

Paragraphs B-2 through B-4 of this appendix were extracted from AR 608-18, appendix B. Paragraphs B-2 through B-5 are provided as a guide and are not all inclusive.

B-1. Definition of child neglect

The passive or active withholding of medicine, food, clothing, treatment, basic hygiene and/or safe environment by a parent or caretaker. *Emotional neglect* involves passive or passive-aggressive inattention to the child's emotional needs, nurturing or psychological well-being.

B-2. Mild child neglect

a. Routine medical and dental exams not provided.
b. Immunizations are not provided or are delayed.
c. Treatment not sought for minor injuries or illnesses where treatment might facilitate faster recovery.
d. Conditions in home place child at risk of minor illness or superficial injury.
e. Lack of supervision places child at risk of minor injury.
f. Isolated incident or no repetitive pattern evident. No readily apparent physical or emotional harm to a child placed in a potentially harmful situation.

B-3. Moderate child neglect

a. Denying food for more than 2 consecutive meals.
b. Locking a child outside when inappropriately dressed or for periods of time which could result in harm or injury.
c. Treatment for illnesses/injuries are usually provided but almost always delayed, though not excessively.
d. Physical needs not met, child at risk of minor distress or discomfort. (Some essential clothing missing, children may be quite hungry, but no actual illness.)
e. Lack of supervision which places the child at risk of serious harm or imminent danger.
f. Physical conditions in the home place child at risk of harm, but are unlikely to require medical treatment (unsanitary or unsafe living conditions).
g. Repeated incidents of neglectful behavior or child suffers physical or emotional harm from circumstances. Short term medical treatment (one time) may be indicated.

B-4. Severe child neglect

a. Driving a motor vehicle with a child passenger while intoxicated.
b. Failure to use child restraint in an automobile.
c. Locking a child in a closet for long periods of time.
d. Forcing a child outside in inclement weather for extended periods of time.
e. Care is not provided for a medical condition that could cause permanent disability if not treated (injury, illness, suicidal threats or gestures).
f. Unreasonable delay in obtaining medical and dental services which endangers the child's life.
g. Failure to thrive diagnosis (absent medical basis, e.g., birth defect, disease, etc.)

h. Failure to give prescribed medication when such failure places child's health or functioning at risk.

i. Physical needs not met, serious illness or injury involved (poor diet, clothing or hygiene).

j. Lack of supervision that results in serious harm or injury.

k. Physical conditions in the home place child at risk of serious harm that would require medical treatment (e.g., exposed wiring, toxic materials within reach).

l. Parent describes exaggerated and/or falsified medical symptoms which result in unnecessary medical tests performed on the child.

m. Pattern of neglectful behavior resulting in hospitalization or alternate placement for the safety of the child.

B-5. Additional indicators that might be seen in a clinical environment

a. Consistent hunger.

b. Inappropriate dress for the outside weather (e.g., no winter coat, no boots, etc.).

c. Poor hygiene.

d. Severe diaper rash.

e. Poor oral hygiene (obvious cavities, decay, etc.).

f. Physical and developmental delay (i.e., non-ill child that doesn't interact with caretakers, staff, and/or other children in the waiting area as expected for that age group).

g. Child isn't supervised by parent in the waiting area.

Appendix C
Child physical abuse

Paragraphs C-2 through C-4 of this appendix were extracted from AR 608-18, appendix B. Paragraphs C-2 through C-5 are provided as a guide and are not all inclusive.

C-1. Definition of child physical abuse

A type of maltreatment that refers to physical acts that cause or may cause physical injury to the victim. *Emotional abuse* often accompanies physical abuse and involves a pattern of active, intentional berating, disparaging or other abusive behavior toward a child that may not cause observable injury.

C-2. Mild child abuse

a. Bruises on legs, arms or buttocks, not requiring medical treatment and confined to one area.

b. Superficial welts, scratches or abrasions.

c. Hair pulling that does not remove hair.

d. Minor physical injury or no medical treatment indicated.

C-3. Moderate child physical abuse

a. Minor burns, blisters, abrasions, confined to a small area on child's arm or leg.

b. Superficial injuries that are very widespread.

c. Small cut requiring stitches.

d. 2nd degree (moderately severe) burns.

e. Sprains, mild concussions, broken teeth.
f. Hair pulling that results in hair removal.
g. Minor or major physical injury; short term medical treatment (one visit) may be indicated.

C-4. Severe child physical abuse

a. Extensive cuts requiring stitches.
b. Head injuries.
c. Internal injuries.
d. 3rd degree burns to any area of the body.
e. Minor burns to an extensive area of the body.
f. Injuries resulting in impairment to sight, hearing or mental impairment.
g. Burns or bruises to the genital area.
h. Extensive and multiple bruises in various states of healing, indicating a pattern of abuse.
i. Cuts, bruises, abrasions on face, neck or shoulders.
j. Minor burns on face or abdomen.
k. Any use of torture such as electric shock or burning with objects.
l. Preventing a child from breathing for a short period of time.
m. Administering to a child any harmful substance or any substance that results in harm to the child.
n. Major physical injury requiring long term medical treatment, inpatient care, or alternate placement.
o. Death.

C-5. Additional indicators that might be seen in a clinical environment

a. Repeated medical treatment/visits for physical injuries.
b. Inadequate, inconsistent or evasive explanation of injuries. Child is not developmentally capable of injuring himself in the way reported.
c. Abnormal affect of the child or caretaker. Caretaker aggressively berates child.
d. Child displays fear toward caretaker.

Appendix D
Spouse Abuse Assessment Guidelines

Paragraphs D-2 through D-4 of this appendix were extracted from AR 608-18, appendix B. Paragraphs D-2 through D-5 are provided as a guide and are not all inclusive.

D-1. Definition of spouse abuse

Use of physical force that causes injury to a spouse. Violence generally used to intimidate, control or force the spouse to do something against his or her will. The forcing of one spouse by another to engage in sexual activity through the use of physical violence, intimidation or the explicit or implicit threat of future violence. *Emotional abuse* is a pattern of acts or omissions, such as violent acts that may not cause observable injury, that adversely affect the psychological well-being of the spouse. Arguments alone are not sufficient to substantiate emotional maltreatment. Property violence may

constitute emotional abuse if intended as a means to intimidate the other spouse.

D-2. Mild spouse abuse

a. Spouse verbally threatened.
b. Mild physical injury or no medical treatment indicated.

D-3. Moderate spouse abuse

a. Something thrown at spouse.
b. Spouse pushed, grabbed or shoved.
c. Spouse slapped.
d. Spouse kicked.
e. Spouse kicked, bit or hit with a fist (once or twice)
f. Minor or major physical injury; short term medical treatment (one visit) may be indicated.

D-4. Severe spouse abuse

a. Any injury during pregnancy.
b. Spouse choked or strangled.
c. Spouse severely beaten (hit, kicked, etc., numerous times).
d. Spouse threatened with a knife or gun.
e. Spouse cut with knife or shot at.
f. Battered spouse syndrome (to include emotional abuse and intimidation).
g. Spouse threatened or hit with a motor vehicle.
h. Spouse sexually abused.
i. Major physical injury or long term medical treatment, in patient care or move to alternate environment for the safety of the spouse.

D-5. Additional indicators that might be seen in the clinical environment

a. Spouse expresses fear or hesitation about returning home.
b. Unusual affect (withdrawn, fearful when spouse is present, etc.)
c. Explanation of the injury is inconsistent with the injury sustained.
d. Dental injuries (lacerations in the mouth and tongue, facial abrasions, broken teeth, jaw or cheek bones).
e. Repeated medical treatment visits for physical injuries.
f. Patient with post-traumatic stress disorder symptoms, which include—
   (1) Depression.
   (2) Anxiety.
   (3) Sleep disorder (nightmares).
   (4) Eating disorder.
   (5) Intrusive thoughts (flashbacks to trauma).
   (6) Substance abuse.
   (7) Suicidality.
   (8) Somatization.
   (9) Victimization of others.
   (10) Hypervigilance.

Appendix E
Abuse and Neglect of Vulnerable Adults

E-1. Definition of abuse of vulnerable adults
Abuse of vulnerable adults (the frail, elderly, developmentally delayed, etc.) is the willful infliction of bodily harm on an adult by a spouse, child, family member, legal guardian, or the primary caretaker. This abuse can be physical, sexual and/or financial in which another person benefits with material goods (personal items, house, money, etc.) without consent of the abused adult.

E-2. Mental anguish
Mental anguish is a state of emotional pain or distress resulting from activity (verbal or behavioral) of a perpetrator. The intent of the activity is to threaten or intimidate, to cause sorrow or fear, to humiliate or ridicule.

E-3. Unreasonable confinement
Unreasonable confinement is the use of restraints (physical or chemical), isolation or any other means of confinement without medical orders, when there is no emergency and for reasons other than the adult's safety or the safety of others.

E-4. Exploitation
Exploitation is the illegal use of an incapacitated adult or his/her resources for another's profit or advantage. This includes acquiring a person's resources through the use of that adult's mental or physical incapacity, misuse of funds, acquiring an advantage through threats to withhold needed support and/or care unless certain conditions are met, persuading an incapacitated adult to perform services, including sexual acts, to which the adult lacks the capacity to consent.

E-5. Neglect
Neglect is the passive or active withholding of medicine, food, clothing, treatment, basic hygiene and emotional support by a spouse, family member, legal guardian or primary caretaker.

E-6. Indicators that might be seen in the clinical environment
a. Frequent injuries such as bruises, cuts, black eyes and burns.
b. Explanation of the injury is inconsistent with the injury sustained.
c. Frequent complaints of pain without obvious injury.
d. Burns or bruises in a pattern that may indicate the use of instruments, restraints or cigarettes.

Glossary

Section I
Abbreviations

CRC
Case Review Committee

DCCS
Deputy Commander for Clinical Services

DCN
Deputy Commander for Nursing

FAP
Family Advocacy Program

HN
head nurse

KACC
Kimbrough Ambulatory Care Center

MEDDAC
U.S. Army Medical Department Activity, Fort George G. Meade

NCOIC
noncommissioned officer in charge

OIC
officer in charge

SWS
Social Work Section

Section II
Terms

Adult abuse
The willful infliction of harm on a vulnerable person; i.e., one older than 60 years, developmentally disabled and/or frail, by a spouse, child, family member, legal guardian or a primary care giver. This abuse can be physical, emotional, sexual, or financial where monies are diverted to another individual without the consent of the affected adult. Indicators of adult physical abuse and neglect of adults are listed in appendix E.

Child abuse
The physical injury, sexual maltreatment, emotional maltreatment, deprivation of necessities, or any other maltreatment by a parent, guardian, or any other person who is responsible for the child's welfare on a temporary or permanent basis. Indicators of child neglect are listed in appendix B and indicators of child abuse are listed in appendix C.

Spouse abuse
Assault, battery, threat to injure or kill, or any other unlawful act of violence, sexual or emotional maltreatment inflicted against one's spouse. Indicators are listed in appendix D.